STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155670	A. BUILDING _____ B. WING _____	R-C 05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER	5233 ROSEBUD LN NEWBURGH, IN 47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00124185 completed on February 19, 2013. This was in conjunction with the Investigation of Complaint IN00127110, Complaint IN00127133, Complaint IN00127285, and Complaint IN00128304. Complaint IN00124185 Corrected. Survey dates: April 29, 30, and May 1, 2013 Facility number: 011049 Provider number: 155670 AIM number: 200258520 Survey team: Anne Marie Crays, RN Census bed type: SNF/NF: 99 Total: 99 Census payor type: Medicare: 16 Medicaid: 62 Other: 21 Total: 99 Sample: 12 Kindred Transitional Care and Rehab - Angel River was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the PSR to the Investigation of Complaint	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 IN00124185. Quality review completed on May 6, 2013, by Jodi Meyer, RN	{F 000}		